Verification of Professional Privileges and/or Employment

The South Dakota Board requires this form to be completed by all professional employers, clinics or hospitals.

Have all facilities where you worked and practiced complete this form and return it to this office. **PLEASE BE AWARE THAT THIS FORM MUST BE COMPLETED BY THE FACILITY WHERE YOU ACTUALLY PRACTICED NOT A CONTRACTING OR PLACEMENT AGENCY BECAUSE SOUTH DAKOTA REQUIRES PRIMARY SOURCE VERIFICATION.**

Name of Current or Previous Facility: _____

Address of Current or Previous Facility: _____

This is your authorization to release any information regarding my privileges and/or employment in your files, favorable or otherwise, directly to: South Dakota Board of Medical & Osteopathic Examiners

_____

(Use BLUE INK: Applicant Signature and Date)

_____

(PRINT Applicant Name and Date)

Below filled out by Facility ONLY:

Conditions under which Applicant, signature above, left (Voluntary or Other) _____

_____

If Other, explain _____

_____

Derogatory Information, if any: _____

_____

Comments, if any: _____

_____

_____

Signature:
Signature Stamp NOT acceptable _____

Print Name: _____

Direct Phone Number: _____

Title: _____

Date: _____

DO NOT FAX –attach additional sheets if needed

MAIL COMPLETED FORM TO:
SDBMOE
125 S. MAIN AVENUE
SIOUX FALLS, SD 57104